Medicaid Mental Health and Mental Health Services Plan
Individuals under 18 years of age
Fee Schedule
July 1, 2003

I. Practitioner Services

Mental health practitioners include physicians, physician assistants, nurse practitioners, psychologists, social workers, and professional counselors. Practitioners bill using standard CPT-4 procedure codes and are reimbursed according to the Department's RBRVS system. Interactive psychotherapy codes are restricted to individuals 12 years of age and younger.

CPT Code	Procedure	Time	Psychologist	LCSW	LCPC
90801	Psychiatric diagnostic interview examination		$79.66	$79.66	$79.66
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter or other mechanisms of communication		$84.80	$84.80	$84.80
90804*	Individual psychotherapy	20 - 30 min.	$34.40	$34.40	$34.40
90806*	Individual psychotherapy	45 - 50 min.	$51.61	$51.61	$51.61
90810*	Individual psychotherapy, interactive	20 - 30 min.	$37.00	$37.00	$37.00
90812*	Individual psychotherapy, interactive	45 - 50 min.	$55.84	$55.84	$55.84
90816*	Individual psychotherapy, inpatient, partial hospital, or residential	20 - 30 min.	$34.66	$34.66	$34.66
90818*	Individual psychotherapy, inpatient, partial hospital, or residential	45 - 50 min.	$52.04	$52.04	$52.04
90823*	Individual psychotherapy, Interactive inpatient, partial hospital, or residential	20 - 30 min.	$37.06	$37.06	$37.06
90826*	Individual psychotherapy Interactive inpatient, partial hospital, or residential	45 - 50 min.	$55.20	$55.20	$55.20
90846*	Family psychotherapy without patient		$50.08	$50.08	$50.08
90847*	Family psychotherapy with patient		$61.07	$61.07	$61.07
90849	Multi family group psychotherapy		$17.29	$17.29	$17.29
90853	Group psychotherapy (other than multi-family)		$16.93	$16.93	$16.93
90857	Interactive group psychotherapy		$18.82	$18.82	$18.82
96100	Psychological testing including psycho-diagnostic assessment of personality, psychopathology, emotionality, intellectual abilities	Per hour	$51.20	NA	$31.74
96105	Assessment of Aphasia	Per hour	$51.20	NA	NA
96115	Neurobehavioral status exam	Per hour	$51.20	NA	NA
96117	Neuropsychological testing battery	Per hour	$76.80	NA	NA

* Individuals may receive a combined total of 24 sessions per year (July 1 through June 30). Additional sessions must be prior authorized.

II. Acute Inpatient Services

Acute care hospital services will be reimbursed for Medicaid beneficiaries under the Montana Medicaid program's Diagnosis Related Group (DRG) reimbursement system. All admissions of Medicaid recipients require prior authorization.

Acute care inpatient treatment is not a benefit under the Mental Health Services Plan.

III. Mental Health Center Services (in addition to practitioner services):

The following table summarizes services available through licensed mental health centers.

Service	Procedure		Modifier		Unit	Reimbur-sement	Co-pay	Limits	Management
	Old	New	1	2					
Respite Care – Youth	Z0651	S5150	HA		15 min	$2.57	None	24 units/24 hours 48 units/mo	Retrospective
Comprehensive School & Community Treatment*		H0036			15 min	$24.46	None	None	Retrospective
Youth Day Treatment	Z0633	H2012	HA		Hour	$9.96	None	6 hours/day	Retrospective
Community-based psychiatric rehabilitation & support – individual	Z0634	H2019			15 min.	$6.17	None	None	Retrospective
Community-based psychiatric rehabilitation & support – group	Z0635	H2019	HQ		15 min.	$1.85	None	None	Retrospective

* CSCT is provided by a public school district that is a licensed mental health center or a school district that has a contract with a licensed mental health center.

IV. Case Management Services

Case management services for youth are available through the Medicaid program when provided by a licensed mental health center under contract with the Department for youth case management.

Service	Procedure	Modifier		Unit	Reimbur-sement	Co-pay	Limits	Management
		1	2					
Targeted Case Management - Youth	T1016	HA		15 min.	$12.00	None	None	Retrospective

V. Therapeutic Youth Group Home Services

The following table summarizes services available by therapeutic youth group homes for Medicaid beneficiaries.

Service	Procedure		Modifier		Unit	Reimbur-sement	Co-pay	Limits	Management
	Old	New	1	2					
Therapeutic Youth Group Home – Moderate level	Z0670	S5145			Day	$87.39	None	None	Prior auth. CON
Therapeutic Youth Group Home –Intensive level	Z0671	S5145	TG		Day	$161.97	None	None	Prior auth. CON
Therapeutic Youth Group Home – Campus based	Z0672	S5145	TF		Day	$132.28	None	None	Prior auth. CON
Moderate Youth Group Home Therapeutic home leave	Z0640	S5145		U5	Day	$87.39	None	14 days/year	Retrospective
Campus-based Youth Group Home Therapeutic home leave	Z0641	S5145	TF	U5	Day	$132.28	None	14 days/year	Retrospective
Intensive Youth Group Home Therapeutic home leave	Z0642	S5145	TG	U5	Day	$161.97	None	14 days/year	Retrospective

VI. Therapeutic Youth Family Care Services

This table summarizes the services available to Medicaid beneficiaries through the therapeutic family (foster) care program.

Service	Procedure		Modifier		Unit	Reimbur sement	Co-pay	Limits	Management
	Old	New	1	2					
Therapeutic Family Care – Moderate level	Z0676	S5145	HR		Day	$40.86	None	None	Prior auth. CON
Moderate Therapeutic Family Care – Therapeutic home leave	Z0643	S5145	HR	U5	Day	$40.86	None	14 days/year	Retrospective
Permanency Therapeutic Family Care	Z0678	S5145	HE	TG	Day	$113.08	None	None	Prior auth. CON
Family-based Services*		H0036	HA		15 min	$20.00		80 units/ month	Prior auth. CON

*Not available on 7/1/2003

VII. Partial Hospitalization

Partial hospitalization services are available to Medicaid (youth and adult) and MHSP (adult only) beneficiaries according to the following schedule:

Service	Procedure		Modifier		Unit	Reimbursement	Co-pay	Limits	Management
	Old	New	1	2					
Acute Partial Hospitalization Full day	Z0912	H0035	U8		Full Day	$151.12	None	28 days*	Prior auth. CON
Acute Partial Hospitalization Half day	Z0913	H0035	U7		Half Day	$113.34	None	28 days	Prior auth. CON
Sub-acute Partial Hospitalization Full day	Z0914	H0035	U6		Full Day	$95.98	None	28 days	Prior auth. CON
Sub-acute Partial Hospitalization Half day	Z0916	H0035			Half Day	$71.99	None	28 days	Prior auth CON

* Maximum recommended to utilization review agency; may be extended if medically necessary.

VIII. Residential Treatment Services

This table summarizes residential treatment services, which are reimbursed for Medicaid beneficiaries.

Service	Procedure	Unit	Reimbursement	Co-pay	Limits	Management
Residential Treatment	Revenue Code 124	Day	$272.77	None	None	Prior auth. CON
Residential Treatment Therapeutic Home Visit	Revenue Code 183	Day	$272.77	None	14 days/year	Prior auth if > 72 hours

* Maximum recommended to utilization review agency; may be extended if medically necessary.